

		FOR OHF USE					

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**2001**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2001)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p><b>I. IDPH Facility ID Number:</b> <u>0026989</u></p> <p><b>Facility Name:</b> <u>THE MCALLISTER NURSING HOME</u></p> <p><b>Address:</b> <u>18300 S. Laverne Ave.</u> <u>Tinley Park</u> <u>60477</u>          Number City Zip Code</p> <p><b>County:</b> <u>Cook</u></p> <p><b>Telephone Number:</b> <u>(708) 798-2272</u> <b>Fax #</b> <u>(708) 798-2220</u></p> <p><b>IDPA ID Number:</b> <u>363147773001</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>1-1-1950</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Gerard C. Schrementi</u> <b>Telephone Number:</b> <u>(708) 748-2808</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01-01-2001</u> to <u>12-31-2001</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1150 678 1283 829" rowspan="2"><b>Officer or Administrator of Provider</b></td> <td data-bbox="1283 678 1923 716">(Signed) _____ <u>3/28/02</u> (Date)</td> </tr> <tr> <td data-bbox="1283 716 1923 753">(Type or Print Name) <u>Theresa Russo</u></td> </tr> <tr> <td data-bbox="1150 829 1283 878" rowspan="2"></td> <td data-bbox="1283 753 1923 797">(Title) <u>President</u></td> </tr> <tr> <td data-bbox="1283 797 1923 829"></td> </tr> <tr> <td data-bbox="1150 829 1283 1040" rowspan="4"><b>Paid Preparer</b></td> <td data-bbox="1283 829 1923 878">(Signed) _____ <u>3/28/02</u> (Date)</td> </tr> <tr> <td data-bbox="1283 878 1923 915">(Print Name and Title) <u>Gerard C. Schrementi</u> <u>CPA</u></td> </tr> <tr> <td data-bbox="1283 915 1923 953">(Firm Name &amp; Address) <u>Gerard C. Schrementi</u> <u>21504 Main St. Matteson, IL 60443</u></td> </tr> <tr> <td data-bbox="1283 953 1923 990">(Telephone) <u>(708) 748-2808</u> <b>Fax #</b> <u>(708) 748-2820</u></td> </tr> <tr> <td colspan="2" data-bbox="1150 990 1923 1131"> <p><b>MAIL TO: OFFICE OF HEALTH FINANCE</b>  <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> <b>Phone # (217) 782-1630</b></p> </td> </tr> </table>	<b>Officer or Administrator of Provider</b>	(Signed) _____ <u>3/28/02</u> (Date)	(Type or Print Name) <u>Theresa Russo</u>		(Title) <u>President</u>		<b>Paid Preparer</b>	(Signed) _____ <u>3/28/02</u> (Date)	(Print Name and Title) <u>Gerard C. Schrementi</u> <u>CPA</u>	(Firm Name & Address) <u>Gerard C. Schrementi</u> <u>21504 Main St. Matteson, IL 60443</u>	(Telephone) <u>(708) 748-2808</u> <b>Fax #</b> <u>(708) 748-2820</u>	<p><b>MAIL TO: OFFICE OF HEALTH FINANCE</b>  <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> <b>Phone # (217) 782-1630</b></p>	
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Facility Name & ID Number THE MCALLISTER NURSING HOME# 0026989 Report Period Beginning: 01-01-2001 Ending: 12-31-2001**III. STATISTICAL DATA**A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>79</u>	Skilled (SNF)	<u>79</u>	<u>28,835</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>32</u>	Intermediate (ICF)	<u>32</u>	<u>11,680</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>111</u>	TOTALS	<u>111</u>	<u>40,515</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>14,796</u>	<u>4,868</u>	<u>945</u>	<u>20,609</u>	8
9	SNF/PED					9
10	ICF	<u>5,240</u>	<u>1,725</u>	<u>335</u>	<u>7,300</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>20,036</u>	<u>6,593</u>	<u>1,280</u>	<u>27,909</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 68.89%D. How many bed-hold days during this year were paid by Public Aid?  
\_\_\_\_\_(Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)  
\_\_\_\_\_F. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?  
YES ☐ NO ☒H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES ☐ NO ☒I. On what date did you start providing long term care at this location?  
Date started 1/1/51J. Was the facility purchased or leased after January 1, 1978?  
YES ☐ Date \_\_\_\_\_ NO ☒K. Was the facility certified for Medicare during the reporting year?  
YES ☒ NO ☐ If YES, enter number  
of beds certified 10 and days of care provided 1,280

Medicare Intermediary \_\_\_\_\_

**IV. ACCOUNTING BASIS**ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12-31-01 Fiscal Year: 12-31-01

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number

THE MCALLISTER NURSING HOME

# 0026989

Report Period Beginning:

01-01-2001

Ending:

12-31-2001

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	175,923			175,923		175,923		175,923		1
2	Food Purchase		171,202		171,202	(22,664)	148,538	(1,098)	147,440		2
3	Housekeeping	158,857			158,857		158,857		158,857		3
4	Laundry	72,735	16,541		89,276		89,276		89,276		4
5	Heat and Other Utilities			100,795	100,795		100,795		100,795		5
6	Maintenance	40,437	27,268	24,167	91,872		91,872		91,872		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	447,952	215,011	124,962	787,925	(22,664)	765,261	(1,098)	764,163		8
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	704,525	33,172	68,488	806,185		806,185		806,185		10
10a	Therapy										10a
11	Activities	76,020	4,174	6,618	86,812		86,812		86,812		11
12	Social Services	40,250			40,250		40,250		40,250		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	820,795	37,346	75,106	933,247		933,247		933,247		16
	<b>C. General Administration</b>										
17	Administrative	89,622			89,622		89,622		89,622		17
18	Directors Fees										18
19	Professional Services			28,256	28,256		28,256		28,256		19
20	Dues, Fees, Subscriptions & Promotions			11,902	11,902		11,902		11,902		20
21	Clerical & General Office Expenses	82,492	85,191	47,405	215,088		215,088		215,088		21
22	Employee Benefits & Payroll Taxes			255,731	255,731	22,664	278,395		278,395		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,308	2,308		2,308		2,308		24
25	Other Admin. Staff Transportation			24,915	24,915		24,915	(17,067)	7,848		25
26	Insurance-Prop.Liab.Malpractice			76,663	76,663		76,663		76,663		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	172,114	85,191	447,180	704,485	22,664	727,149	(17,067)	710,082		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,440,861	337,548	647,248	2,425,657		2,425,657	(18,165)	2,407,492		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

Page 4

Facility Name &amp; ID Number THE MCALLISTER NURSING HOME

#0026989

Report Period Beginning:

01-01-2001

Ending:

12-31-2001

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			49,575	49,575		49,575	94,707	144,282			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			27,221	27,221		27,221	227,619	254,840			32
33	Real Estate Taxes			212,649	212,649		212,649		212,649			33
34	Rent-Facility & Grounds			268,454	268,454		268,454	(268,454)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			557,899	557,899		557,899	53,872	611,771			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			64,371	64,371		64,371		64,371			39
40	Barber and Beauty Shops			1,435	1,435		1,435		1,435			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			51,475	51,475		51,475		51,475			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			117,281	117,281		117,281		117,281			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,440,861	337,548	1,322,428	3,100,837		3,100,837	35,707	3,136,544			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name &amp; ID Number THE MCALLISTER NURSING HOME

# 0026989

Report Period Beginning:

01-01-2001

Ending:

12-31-2001

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	26,789	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,098)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(17,067)	25		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Non Care Depreciation	(625)	30		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 7,999		\$	30

OHF USE ONLY							
48		49		50		51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	27,708		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 27,708		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ 35,707		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS  
THE MCALLISTER NURSING HOME

Page 5A

ID# 0026989  
Report Period Beginning: 01-01-2001  
Ending: 12-31-2001

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
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32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number THE MCALLISTER NURSING HOME

# 0026989

Report Period Beginning:

01-01-2001

Ending:

12-31-2001

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,098)	0	0	0	0	0	0	0	0	0	0	(1,098)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(1,098)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,098)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(17,067)	0	0	0	0	0	0	0	0	0	0	(17,067)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(17,067)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(17,067)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(18,165)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(18,165)</b>	<b>29</b>





**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.**   
☐ YES   
☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	30	Depreciation	\$	McAllister Partners	100.00%	\$ 68,543	\$ 68,543	1
2	V	34	Rent	268,454				(268,454)	2
3	V	32	Interest				227,619	227,619	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 268,454			\$ 296,162	\$ * 27,708	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

## STATE OF ILLINOIS

Page 7

Facility Name & ID Number THE MCALLISTER NURSING HOME # 0026989 Report Period Beginning: 01-01-2001 Ending: 12-31-2001

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	Theresa Russo	President	Adm.	35.00		40	100.00		\$ 48,721	1
2	Angeline Olivotto	Secretary	Bookkeeping	33.00		40	100.00		29,571	2
3	Geraldine Wagner	Director	Ass't Adm.	16.00		40	100.00		40,900	3
4	Deena Rush	Director	Ward Clerk	16.00		40	100.00		40,100	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$ 159,292	13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number THE MCALLISTER NURSING HOME # 0026989 Report Period Beginning: 01-01-2001 Ending: 2-31-2001

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Pullman Bank		X	Mortgage	\$22,371.00	6-16-00	\$ 2,400,000	\$ 2,340,468	6-15-15	9.5000	\$ 227,619	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Pullman Bank		X	Working Capital		5-1-98	500,000	498,639			27,221	6	
7												7	
8												8	
9	TOTAL Facility Related				\$22,371.00		\$ 2,900,000	\$ 2,839,107			\$ 254,840	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 2,900,000	\$ 2,839,107			\$ 254,840	15	

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Facility Name &amp; ID Number THE MCALLISTER NURSING HOME

# 0026989 Report Period Beginning: 01-01-2001 Ending: 12-31-2001

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

## B. Real Estate Taxes

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2000 report.		\$	153,226	1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	182,938	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	29,712	3	
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	182,938	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	212,650	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	1996	154,151	8		
	1997	150,453	9		
	1998	203,957	10		
	1999	147,799	11		
	2000	148,967	12		
				<b>FOR OHF USE ONLY</b>	
				13	FROM R. E. TAX STATEMENT FOR 2000 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

## NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2000 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME THE MCALLISTER NURSING HOME COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0026989

CONTACT PERSON REGARDING THIS REPORT Gerard C. Schrementi

TELEPHONE (708) 748-2808 FAX #: (708) 748-2820

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>28-33-403-007</u>	<u>Nursing Home Property</u>	\$ <u>36,360.26</u>	\$ <u>36,360.26</u>
2. <u>28-33-403-006</u>	<u>Nursing Home Property</u>	\$ <u>143,681.15</u>	\$ <u>143,681.15</u>
3. <u>28-33-403-008</u>	<u>Nursing Home Property</u>	\$ <u>2,896.46</u>	\$ <u>2,896.46</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>182,937.87</u></u>	\$ <u><u>182,937.87</u></u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES   X   NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:
 37,050

B. General Construction Type:
 Exterior
 Brick
 Frame
 Number of Stories
 1

C. Does the Operating Entity?
 ☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:
 \_\_\_\_\_

2. Number of Years Over Which it is Being Amortized:
 \_\_\_\_\_

3. Current Period Amortization:
 \_\_\_\_\_

4. Dates Incurred:
 \_\_\_\_\_

Nature of Costs:
 \_\_\_\_\_  
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Care	217,800	1948	\$ 50,000	1
2					2
3	TOTALS	217,800		\$ 50,000	3

Facility Name &amp; ID Number THE MCALLISTER NURSING HOME

# 0026989

Report Period Beginning:

01-01-2001 Ending: 12-31-2001

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
Bed*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4		1982	1982	\$ 97,585	\$ 3,253	30	\$ 3,253	\$ 3,253	\$ 62,618
5	59	1977	1977	530,796	17,693	30	17,693		458,192
6	42	1955	1955	17,500		30			17,500
7	10	1999	1999	2,001,372	50,035	39	50,035		102,154
8		2000	2000	32,600	815	39	815		1,596
<b>Improvement Type**</b>									
9	Improvements			519,444	4,128	25	4,128		517,379
10	Windows Roof	1984		48,985	979	30		(979)	48,985
11	Painting Wallpaper	1985		8,159	299	15		(299)	8,159
12	Water Heater	1985		3,775		15			3,775
13	Roof Signs Window	1988		13,042		20	652	652	8,903
14	Roof Water Htr Floor	1989		25,565		10			25,565
15	Remodel Office	1990		39,584	1,257	31	990	(267)	11,257
16	Roof Tile and Carpeting	1990		7,696		10			7,696
17	Doors Stairwell Storage	1991		23,621		10	1,181	1,181	23,621
18	Parking Lot and Fence	1993		66,521	4,024	10	6,652	2,628	56,116
19	Access Ramp	1994		8,631	566	10	863	297	6,473
20	Dining Room	1995		85,925	2,148	39	2,148		14,589
21	Fence Doors and Floor	1995		17,678	947	10	1,768	821	10,828
22	Nurses Station	1996		33,389	3,339	10	3,339		18,364
23	Plumbing Vent Stacks and Drains	1997		12,400	1,048	10	1,240	192	6,045
24	Kitchen Duct and Ceiling	1997		4,920	416	10	492	76	2,399
25	Parking Lot	1997		8,290	700	10	829	129	4,041
26	Laundry Improvements	1997		8,555	723	10	855	132	4,170
27	Architect	1997		16,773	1,503	10	1,677	174	7,757
28	Doors	1997		1,259	143	5	252	109	1,165
29	Roof and Desk	1997		15,730	1,509	10	1,573	64	6,785
30	Landscaping	1997		11,408	1,139	10	1,141	2	4,706
31	Paint and Wallpaper	1997		8,176	895	5	1,635	740	6,745
32	Roof	2000		25,145	4,526	10	2,515	(2,011)	3,772
33									
34									
35									
36									

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total



XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,694,524	\$ 98,832		\$ 105,726	\$ 6,894	\$ 1,451,355	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 298,764	\$ 18,662	\$ 38,556	\$ 19,894		\$ 234,724	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	295,480					295,480	73
74								74
75	TOTALS	\$ 594,244	\$ 18,662	\$ 38,556	\$ 19,894		\$ 530,204	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Care	1995 GMC Pickup	1995	\$ 22,276	\$	\$	\$		\$ 22,275	76
77										77
78										78
79										79
80	TOTALS			\$ 22,276	\$	\$	\$		\$ 22,275	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,361,044	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 117,494	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 144,282	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 26,788	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,003,834	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Ice Cream Shoppe	\$ 25,000	\$ 625	\$ 4,193	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 25,000	\$ 625	\$ 4,193	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	5/1/1955	42		\$ 268,454			3
4	Additions	5/1/1957	59					4
5		12/22/1999	10					5
6								6
7	TOTAL		111		\$ 268,454			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease \_\_\_\_\_.

9. Option to Buy: ☐ YES ☐ NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_/2002 \$ \_\_\_\_\_

13. \_\_\_\_\_/2003 \$ \_\_\_\_\_

14. \_\_\_\_\_/2004 \$ \_\_\_\_\_

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

**A. TYPE OF TRAINING PROGRAM** (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b>  <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<b>2. CLASSROOM PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  COMMUNITY COLLEGE <input type="checkbox"/>  HOURS PER AIDE _____	<b>3. CLINICAL PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  HOURS PER AIDE _____
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$ \_\_\_\_\_

**D. NUMBER OF AIDES TRAINED**

<b>COMPLETED</b>	
1. From this facility	
2. From other facilities (f)	
<b>DROP-OUTS</b>	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
10	Academic Education		hrs							11
11	Exceptional Care Program									12
12	Other (specify):									13
13										
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (17,534)	\$	1
2	Cash-Patient Deposits	12,425		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	451,757		3
4	Supply Inventory (priced at )	2,000		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 448,648	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,126,515		15
16	Equipment, at Historical Cost	616,519		16
17	Accumulated Depreciation (book methods)	(1,516,821)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 226,213	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 674,861	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 216,496	\$	26
27	Officer's Accounts Payable	221,125		27
28	Accounts Payable-Patient Deposits	12,425		28
29	Short-Term Notes Payable	498,638		29
30	Accrued Salaries Payable	36,364		30
31	Accrued Taxes Payable (excluding real estate taxes)	18,056		31
32	Accrued Real Estate Taxes(Sch.IX-B)	182,938		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,186,042	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<b>Shareholder Loans</b>	23,672		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 23,672	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,209,714	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (534,853)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 674,861	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(495,895)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(495,895)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>65,312</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(104,270)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(38,958)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(534,853)</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

**VII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 3,166,025	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,166,025	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	125	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 125	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,166,150	30

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	787,925	31
32	Health Care	933,247	32
33	General Administration	704,485	33
	<b>B. Capital Expense</b>		
34	Ownership	557,899	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	117,282	35
36	Provider Participation Fee		36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,100,838	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	65,312	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 65,312	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.



Facility Name &amp; ID Number THE MCALLISTER NURSING HOME

# 0026989

Report Period Beginning: 01-01-2001

Ending:

12-31-2001

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,000	2,080	\$ 43,310	\$ 20.82	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,243	7,879	133,494	16.94	3
4	Licensed Practical Nurses	10,507	11,099	168,992	15.23	4
5	Nurse Aides & Orderlies	36,994	38,818	336,359	8.67	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,444	2,524	22,371	8.86	8
9	Activity Director	4,000	4,080	46,707	11.45	9
10	Activity Assistants	3,960	4,072	29,313	7.20	10
11	Social Service Workers	2,000	2,080	40,250	19.35	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,911	2,375	21,569	9.08	14
15	Cook Helpers/Assistants	19,520	19,744	154,354	7.82	15
16	Dishwashers					16
17	Maintenance Workers	2,000	2,080	40,437	19.44	17
18	Housekeepers	18,270	19,742	158,857	8.05	18
19	Laundry	9,072	10,078	72,735	7.22	19
20	Administrator	2,000	2,080	48,721	23.42	20
21	Assistant Administrator	2,000	2,080	40,900	19.66	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,456	8,708	82,492	9.47	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	132,377	139,519	\$ 1,440,861 *	\$ 10.33	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 5,180	10-3	35
36	Medical Director				36
37	Medical Records Consultant		1,286	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant		51,570	10-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		9,056	10-3	44
45	Social Service Consultant		1,396	10-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 68,488		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

## XIX. SUPPORT SCHEDULES

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount			
Theesa Russo	Adm	35	\$ 48,722	Workers' Compensation Insurance	\$ 46,595	IDPH License Fee	\$ 40			
Geraldine Wagner	Ass't Adm.	16	40,900	Unemployment Compensation Insurance	23,432	Advertising: Employee Recruitment	6,196			
				FICA Taxes	111,466	Health Care Worker Background Check (Indicate # of checks performed _____)				
				Employee Health Insurance	74,238	Dues and Subscriptions	5,666			
				Employee Meals	22,664					
				Illinois Municipal Retirement Fund (IMRF)*						

**\* Attach copy of IMRF notifications**

**\*\*See instructions.**

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

[illegible]

Facility Name & ID Number THE MCALLISTER NURSING HOME

STATE OF ILLINOIS

# 0026989

Report Period Beginning: 01-01-2001

Page 23

Ending: 12-31-2001

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO  
If YES, give association name and amount. IHCA
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line \_\_\_\_\_
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 51,476  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 22,664 Has any meal income been offset against related costs? NO Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? \_\_\_\_\_ If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? \_\_\_\_\_  
d. Have vehicle usage logs been maintained? \_\_\_\_\_  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? \_\_\_\_\_  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? \_\_\_\_\_  
**g. Does the facility transport residents to and from day training? NO**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? NO If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees.